LEGISLATIVE AUDIT COMMISSION

Program Audit
Office of the Inspector General
Department of Human Services

December 2004

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217/782-7097

PROGRAM AUDIT
OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF HUMAN SERVICES

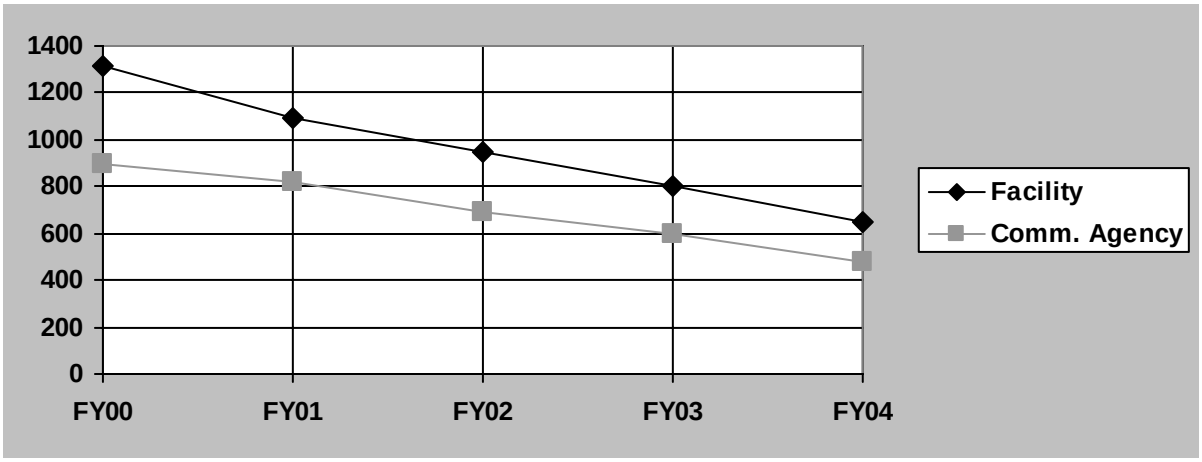
DECEMBER 2004
Recommendations – 12

Summarized below are the recommendations contained in the program audit of the Office of the Inspector General, Department of Human Services. The program audit was conducted by the Office of the Auditor General pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. The Act states that the audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse and make recommendations for sanctions to DHS and the Department of Public Health. The Inspector General during the audit period was Dr. Sydney R. Roberts, and she was appointed May 19, 2003. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term.

The General Assembly established the Office of the Inspector General (OIG) in 1987. The purpose of the OIG is to investigate allegations of abuse or neglect reported within State-operated facilities and programs serving the mentally ill and developmentally disabled, as well as at facilities or programs licensed, certified or funded by DHS. In FY04, DHS operated 17 State facilities and licensed, certified, or funded over 400 community agencies. The 17 facilities served 12,167 individuals. The 400 community agency programs provided services to approximately 24,500 individuals with developmental disabilities and approximately 168,000 individuals with mental illness.

Allegations of abuse and neglect reported to the OIG have been steadily decreasing over the last several years. In FY04, a total of 1,127 allegations of abuse or neglect were reported to the OIG, 645 from State facilities and 483 from community agencies.

Allegations of Abuse and Neglect



The OIG has made three important changes affecting the allegation reporting process. As a result of these changes, the number of allegations reported to the OIG has decreased significantly during this audit period. The three changes are: The OIG now requires direct reporting of allegations to the OIG Hotline; serious injury allegations are not longer reportable conditions; and the definition of neglect has been narrowed.

As a result of these changes:

- If Intake staff determine it is not a reportable allegation, the allegation is not entered into the database, thus reducing the number of inappropriate cases from being investigated.
- The OIG now considers serious injuries without an aggregation of abuse or neglect to be not reportable.
- The OIG's position that harm is required to substantiate mental injury or neglect is eliminating cases that the OIG believed to be substantiated allegations of abuse and neglect.

When the auditors reviewed the OIG's Directives, they found that vague investigative guidance may continue to leave investigative staff, especially new investigators, unclear on appropriate investigative requirements. The current OIG Directives in comparison to the former Guidelines have omitted important detail in the areas of photographing and collection and handling of physical evidence. Additionally, the OIG does not mandate the use of the investigative checklist by the investigators. Neither the OIG nor the State Police are fulfilling statutory responsibilities established under the Act because there is no guidance related to allegations involving non-State employees such as employees at community agencies.

The OIG changed the definition of days from calendar to a more lenient working days in its administrative rules in January 2002. Since this rule change came about in January 2002, the auditors further determined that only 46% of allegations were investigated within 60 working days in FY03 and 51% in FY04. The number of cases taking more than 200 days to complete increased from 41 in FY02 to 258 in FY04.

In FY04, the OIG substantiated abuse or neglect in 197 of 1,455 closed investigations of incidents reported to the OIG. 7% of the cases in facilities were substantiated, while 22% of the cases in community agencies were substantiated.

As of May 2004, the OIG had 61 staff. This represents a decrease of seven positions from staffing levels reported in the FY02 audit. Investigative staff for abuse or neglect decreased from 39 in FY2000 to 27 in FY02, to 22 (including two investigators on leave) in FY04.

According to Appendix A, the OIG closed 1,585 cases in FY03 and 1,639 cases in FY04. There are 28 allegation descriptions divided into four categories: abuse, neglect, death, and other reportable incidents. More than 41% of all allegations are described physical abuse without serious harm alleged. The percentage of allegations substantiated was 8% in FY03, and 12% in FY04. The percentage of allegations substantiated in FY04 at

the individual DHS facilities varied from 0% at Madden and McFarland to 43% at Mabley for six cases. Kiley had the greatest number of substantiated cases—10%, or 22%.

Recommendations

1. **Assure that clear and consistent investigative guidance is available for investigators by amending the Directive to include specific guidance in the Inspector General should also require that photographs are taken in all areas of photographing and the handling and collection of evidence. The instances where physical injury is alleged. In addition, the Inspector General should mandate the use of the Investigative checklist. This would aid both investigators and Bureau Chiefs in conducting and reviewing an investigation.**

Findings: In the 2002 audit of the OIG, the auditors recommended that the OIG assure that investigators have clear and consistent guidance. The OIG addressed this recommendation and during this audit period operated under one version of its administrative rules. The OIG also rescinded all Investigative Guidelines and replaced them with a complete set of Investigative Directives.

During a review of the OIG's Directives, the auditors found that vague investigative guidance may continue to leave investigative staff, especially new investigators, unclear on appropriate investigative requirements. The current OIG Directives in comparison to the Guidelines have omitted important details in the areas of photographing and the collection and handling of physical evidence. These elements of an investigation are now left to the judgment of the investigator and if not followed properly might impede the investigation.

In the former OIG Guidelines, photographs were required in all instances where an injury had been sustained as a result of an incident. Also, the Guidelines provided detailed instructions on how and what to photograph during an investigation. The use of photographs is now left to the judgment of the investigator. There is no additional guidance in the Directives concerning the detailed instructions that was contained in the former Guidelines. Photographs were not taken in 40 of 52 cases sampled in FY04 where there was an allegation of an injury sustained.

Another crucial investigative area that has been left to the judgment of investigators is the proper handling and collection of evidence from an investigative scene. The former Guidelines provided detailed steps on how to collect and preserve evidence.

The Directives manual contains a checklist that lists the steps an investigator may perform while conducting an investigation. This checklist includes taking photographs and collecting physical evidence. The checklist only lists the steps, and does not detail specific instances where photographs should be taken or how evidence is to be collected. Use of the checklist by the investigators is not required unless mandated by the Bureau Chief. During file testing, 25 of 125 case files contained an investigative checklist.

OIG Response: The Office of Inspector General ("OIG") agrees that each investigation should have a written plan of action prior to the commencement of any investigation to ensure that all investigations proceed in a timely manner. However, OIG contends that staff are provided with clear and consistent investigative direction; in fact, we note that in but two instances did the audit find OIG's directives to be vague. First, newly hired investigators must complete an extensive 3 month training program which clearly and explicitly explains the entire investigative process, covering such topics as investigative planning, the collection of evidence and when and how to take photographs. Moreover, all OIG staff receive the OIG training manual which clearly outlines exactly how to collect different types of evidence as well as how and when to take photographs. Thus, while the Directives Manual does not cover all investigative techniques, the Training Manual does provide this level of detail and serves as a "How To" guide. Secondly, this information is reiterated at bureau meetings, in net-learning modules, and in-service training classes. OIG urges the Auditor General to recognize that certain critical investigative decisions must be left to the discretion of investigators and their supervisors to ensure that we devote our resources where most beneficial to the investigation. We specifically take issue with any recommendation that OIG formulate a directive requiring investigators to take photographs in all physical abuse cases. Where the taking of a photograph will not reveal evidence nor disprove evidence of an injury, photographs are of no evidentiary value, are not fiscally prudent, and are not an efficient use of investigative time. In fact, photographs that do not show an apparent injury can undermine a substantiated finding of physical abuse.

AUDITOR COMMENT: *As noted by the Inspector General, evidence handling is addressed in training manuals and net-learning modules, and reiterated at bureau meetings and in-service training classes. The auditors concluded that evidence handling also should be included in the Directives that are intended to provide guidance to investigators (as prior OIG Investigations Guidelines have done). Specifically regarding photographs, the auditors stand by the recommendation that photographs should be taken in all abuse and neglect cases where injuries are alleged. Furthermore, the Inspector General's position in response to this audit report appears to contradict both the OIG's community agency protocol and OIG training materials. The protocol still requires photographs to be taken "when injuries are the result of an alleged incident of abuse or neglect . . . even if the injury is not evident at the time of report/discovery."*

2. The Inspector General should take the following actions:

- **capture data for all allegations of serious injuries in its database;**
- **require all resident on resident incidents be reported;**
- **ensure that all injuries which meet the statutory definition of abuse or neglect are reported and adequately investigated; and**
- **clarify its definitions of neglect and mental injury to ensure that all cases of abuse and neglect are reported. In addition, training should be provided to ensure that all necessary individuals understand these definitions.**

Findings: Total incidents of alleged abuse and neglect and serious injuries reported to the OIG have decreased significantly since FY2000. In FY2000, 3,925 incidents were reported (1,626 abuse, 585 neglect, and 1,714 serious injury). In FY04, only 1,127 incidents were reported (933 abuse, 194 neglect, and 0 serious injury). The OIG has made three important changes affecting the allegation reporting process. As a result of these changes, the number of allegations reported to the OIG has decreased significantly during this audit period.

All facilities and community agencies are now reporting allegations of abuse and neglect by calling into the OIG Hotline. This allows OIG Intake staff to make an assessment as to whether the allegation is abuse or neglect, thus reducing the number of inappropriate cases from being investigated.

If Intake staff determines it is not a reportable allegation, the allegation is not entered into the database. If all incidents were captured, it would allow for quality assurance by a supervisor to ensure that all reportable cases are being investigated.

The OIG now considers serious injuries without an allegation of abuse or neglect to be not reportable. In the past, these cases were reported and were investigated by the OIG even though there was no allegation of abuse or neglect. The OIG has made the interpretation that it is not required to investigate these serious injury cases and has taken the necessary steps to ensure that these cases are no longer reported or investigated. Exhibit 1-5 shows that serious injury cases reported have decreased from 1,714 in Fiscal Year 2000 to 0 in Fiscal Years 2003 and 2004.

The OIG's interpretation of the definitions for neglect and mental injury appear to have reduced the number of cases reported and the number of cases substantiated. Neglect now requires harm or deterioration in the individual's condition.

In FY02, two category codes combined for 408 allegations and 93 substantiated cases. In FY04, the two combined for 108 allegations and 29 substantiated cases. Therefore, substantiated cases decreased 69% in these two categories. The OIG's position that harm is required to substantiate mental injury or neglect is eliminating cases that the OIG believed to be substantiated allegations of abuse and neglect in the past.

OIG Response: OIG's current operating procedures do ensure that all allegations of abuse and neglect as defined by 59 Ill. Admin. Code 50, (Rule 50), are reported and thoroughly investigated. Moreover, although the language of the audit report suggests otherwise, the report fails to demonstrate that allegations are not being reported or thoroughly investigated in accordance with both the statute and Rule 50. While an argument can be made that capturing data on serious injuries may reveal evidence of abuse or neglect, OIG's years of research and analysis of data revealed that most often serious injuries were the result of an accident or the individual engaging in self-injurious behaviors. Such injuries, though a matter of concern, are not covered by 210 ILCS 30/6.2 et. seq nor Rule 50 and fall outside our purview. Additionally, this information as well as resident on resident incidents are captured and analyzed by the DHS Division of Mental

Health and the Division of Developmental Disabilities, state operated facilities and community agencies. These are quality assurance issues, not an issue of abuse and neglect. Where abuse or neglect is suspected, the division will contact OIG and an investigation will commence. To ensure the most efficient use of our resources, Rule 50 was amended in 2002 and no longer requires the reporting of serious injuries absent an allegation of abuse or neglect. Lastly, we encourage the Auditor General to review the amended definition of mental injury as it subsumes both the old definitions of verbal and psychological abuse.

AUDITOR COMMENT: *The Inspector General notes that serious injuries are a matter of concern but are not covered by 210 ILCS 30/6.2. In fact, the Abused and Neglected Long Term Care Facility Residents Reporting Act defines "abuse" as "**any physical injury, sexual abuse or mental injury inflicted on a resident other than by accidental means".** This broad statutory definition seems to include injuries to residents, unless they are clearly accidental. Regarding neglect and mental injury, the auditors noted a 79 percent decrease in mental injury (verbal) allegations from fiscal year 2002 to 2004, and a 64 percent decrease in neglect with risk of harm or injury allegations over the same time period. Because of this large decrease in incidents, it does not appear that the old definition has been fully "subsumed" into the new one.*

3. The Office of the Inspector General and State Police should assure that notification and investigation requirements in the Abused and Neglected Long Term Care Facility Residents Reporting Act are satisfied (210 ILCS 30/6.2 (b)). This should include an interagency agreement that stipulates responsibilities and should include revising the current administrative rules to be consistent with the Act (59 Ill. Adm. Code 50.50 h).

Findings: Neither the OIG nor the Illinois State Police are fulfilling statutory responsibilities established under the Abused and Neglected Long Term Care Facility Residents Reporting Act.

The OIG and the Illinois State Police signed an interagency agreement in January 2003. The agreement, however, does not meet the statutory requirement established by the Act. The agreement provides guidance related to allegations involving State employees but not allegations against non-State employees (such as employees at community agencies) where evidence indicates a possible criminal act.

The most recent version of the OIG's administrative rules does not require the OIG to report all possible criminal acts to State Police as required by statutes. The OIG amended the section on reporting to State Police to say State Police or local law enforcement authorities, as appropriate.

OIG Response: The OIG provided the Auditor General with OIG's legislative proposal, which was not enacted, to give OIG the authority to contact the local law enforcement authority upon a report of a possible felony. OIG intends to again submit the

proposal during the 95th Legislative Session. Although it is not the practice of the Illinois State Police to investigate such matters that occur in non-state facilities and involve non-state employees, OIG will contact ISP pending passage of the legislative proposal. However, to ensure that crimes against the disabled in non-state facilities are thoroughly investigated, OIG will continue to contact the local police department.

State Police Response: Concur. The ISP is collaborating with the DHS to re-draft an interagency agreement to comply with the statutory requirements set forth under the Abused and Neglected Long Term Care Facility Residents Reporting Act. Additionally, while past efforts have met with little success, both agencies will continue to work toward ensuring current administrative rules are consistent with the Act.

4. The Inspector General should continue to work to improve the timeliness of investigations of abuse and neglect.

Findings: The OIG changed the definition of days in administrative rules in January 2002 to be working rather than calendar days. Sixty working days generally works out to over 80 calendar days.

Timeliness of investigations has been an issue in all of the seven previous OIG audits. During this audit period, the OIG continued to have problems completing investigations timely. In FY02, 46% of investigations were completed in 60 calendar days, while in FY03 only 30% and in FY04 only 39% were completed in 60 calendar days.

In FY01, the average number of calendar days to complete an investigation was 90 and the median was 62. In FY02, the average decreased to 76 days and the median was 64 days. During FY03 and FY04, the average and median days to complete an investigation of abuse or neglect increased significantly from FY02. In FY03, the average was 106 and the median was 97. In FY04, the average increased to 109 days but the median decreased to 87 days.

The number of cases taking more than 200 calendar days to complete has also increased significantly from FY02. In FY02, 41 cases took longer than 200 days to complete. By FY04, the cases taking longer than 200 days to complete increased to 258.

OIG Response: OIG will continue to work to improve the timeliness of investigations. At the end of the first quarter of FY05, the average number of days required to complete investigations was shortened to 47.6 days. However, OIG takes issues with the reference that OIG has a more lenient time requirement for completing cases. Under the old Rule 50, investigators had 60 calendar days to complete an investigation. Because OIG investigators do not work holidays or weekends, this interpretation did not provide the investigator with 60 days but rather considerably less, particularly during a month in which there was a holiday. Converting to working days is a much fairer, not lenient, interpretation of the 60 day requirement.

AUDITOR COMMENT: *The audit continues to report timeliness on a calendar basis for comparison purposes over time. Additionally, using working days is a more lenient time requirement. Using working days, the OIG has over 80 calendar days to complete an investigation compared to the 60 calendar day requirement.*

5. The Inspector General should maintain the necessary documentation to monitor referrals to the Illinois State Police. Monitoring should be in place to ensure that the referrals are timely as required by State law.

Findings: The OIG does not maintain documentation to record when cases are referred to the Illinois State Police. Statutes require that the OIG notify State Police for all allegations where a possible criminal act has been committed, or where special expertise is required in the investigation.

In the auditors' testing of Fiscal Year 2004 cases, five cases were referred to State Police. The OIG refers these cases to the State Police by telephone and does not keep a record of these calls in the case files.

OIG Response: The Auditor General noted in numerous places throughout the report that OIG does not keep a record in our case file of when we refer cases to the Illinois State Police. However in their 5 case sampling OIG referred to the case file and was in fact able to provide them with the dates of referrals. Thus, their contention that OIG does not maintain this data is not supported by their own narrative. OIG reminds the Auditor General that our investigators may not uncover evidence of a crime for some time after initiating an investigation, which is only fitting to avoid burdening law enforcement with non-criminal matters. In the one case mentioned by the Auditor General, it was not clear upon review of the intake that this case was appropriate for referral. Only after the investigator completed several investigative steps did he uncover evidence of possible criminal conduct. Thus, once OIG obtained the requisite evidence, the referral was made immediately, consistent with the other cases involving police referrals reviewed in this audit. OIG is currently developing an electronic case management system which will include a component for capturing cases referred to the Illinois State Police.

AUDITOR COMMENT: *To test compliance with the reporting requirement to State Police, we requested documentation from the OIG for the five cases in our sample referred to the State Police. We were told by OIG staff that no documentation was maintained. On August 26, 2004, auditors sent an e-mail to the Inspector General to verify that documentation was not kept. We subsequently received referral dates to the State Police from the OIG, but the OIG did not provide documentation, such as fax referral sheets. We noted that one of the referral dates differed from the date in OIG's computer system. Since the OIG provided two different dates for the same case, we requested and received the documentation for the one case from the State Police. The date in OIG's computer system was incorrect. The case was not investigated by the OIG for five days and was not reported to the State Police for nine days.*

6. The Inspector General should develop specific time requirements for conducting interviews of the alleged perpetrator, victim, and any witnesses. Consideration should be given to interviewing the accused after the alleged victim has been interviewed.

Findings: Timely interviews of alleged victims and perpetrators are important because as time passes memories may fade or witnesses may become unavailable for follow-up interviews. Even though initial statements are often taken at the time of the incident, delays in getting detailed interviews from those involved, especially from the alleged victim, increase the risk of losing information and weakening the evidence obtained. Current OIG Directives do not specifically designate a required timeline for conducting interviews with those involved.

During the auditors' case file review, the OIG investigators were not always conducting their interviews with the alleged victims in a timely manner. The average time to interview the victims from our sample was 37 days. In addition, in 27 of 89 cases where data was relevant, the victim either recanted the allegation (19), did not remember the incident (5), or refused to cooperate (3). The average time it took OIG investigators to interview victims in these 27 cases was 43 days. Timely interviews of the victims are imperative to ensure an effective and thorough investigation.

Since there was a high percentage of individuals who recanted the allegation, said that they did not remember, or refused to cooperate from our sample, the auditors looked for reasons that may contribute to the result. In addition to the timeliness of the interview, the auditors found several instances where the accused staff member was interviewed before the victim. In several cases it was months or weeks earlier.

In one case, it was alleged that the victim was choked by one staff member, slapped by another, and hit with an ink pen by a third staff member. The alleged perpetrators were interviewed in December 2003. The alleged victim was not interviewed until April 2004 at which time he indicated that he made up the allegation.

OIG Response: Although we agree with this Recommendation's aim of completing case reviews faster, we believe that instituting a case management system (Recommendation 7) will achieve this goal more effectively. As noted, this office already directs investigators to interview certain individuals within specific time frames. Establishing additional interim deadlines may expose otherwise thorough and timely investigations to meaningless criticism. Each investigation is unique, so effective case management depends upon giving investigators the appropriate flexibility and discretion to conduct interviews and compile evidence in a manner that leads to a thorough and efficient conclusion. For example, although this office instructs investigators to interview the victim before the alleged perpetrator, factors present in individual cases may not allow such an orderly progression. Unforeseen unavailability of witnesses and efficiency may sometimes require an investigator to interview other available witnesses after

traveling several hours to the location. Forcing investigators to follow an excessively formulaic approach will hamper their ability to react to specific situations and exercise good judgment appropriately. We urge the Auditor General to maintain focus on the goal of completing cases within sixty days, and the case management system as the best tool for achieving that goal, rather than upon interim deadlines.

AUDITOR COMMENT: *The audit is not proposing a formulaic approach to investigations, but rather, recommending a control mechanism to help ensure that interviews are conducted in a timely manner. An average timeframe of 43 days, based on our sample, to interview victims for facility and community agency cases, is too long. If the OIG has other methods or controls to help ensure that interviews are completed more timely, we suggest that they implement them.*

7. The Inspector General should develop an electronic case management system to help manage investigation and case file review timeliness.

Findings: Data from the OIG database shows that none of the four investigative bureaus is reviewing substantiated cases within the timelines delineated in OIG Directives. OIG Directives allow the Investigative Team Leader (ITL) and Bureau Chief each 5 working days to review substantiated and priority cases and 10 working days to review unsubstantiated and unfounded cases. The Metro Bureau takes much longer to review unsubstantiated cases than the other three bureaus, which may be due to the fact that it has an additional review from the ITL.

The OIG does not have an effective case management system in place to adequately monitor the timeliness of case completions. The OIG's case management system is not an electronic system but is a series of manually prepared reports.

The directive specifically requires investigators to complete Case Status Reports to submit to their supervisor for all cases not completed within 30 and 45 working days of assignment. The directive also requires the Bureau Chiefs to submit monthly reports to the Inspector General or his/her designee by the 15th day of each month identifying all cases more than 45 days old. This is referred to as the 45-Day Status Report. The report must include the reason for the delay, actions to complete the investigation, and the expected date for completion.

The monthly 45-Day Status Reports submitted by the Bureau Chiefs did not include all the information required by the Investigative Directive. The reports did not have a standard format and varied by investigative bureau. The Bureau of Support Services can run a 45-Day Status Report as of a particular day, which would only contain cases open in excess of 45 days. This report contains the case number, the number of days open, and the investigator name. However, it does not include any information as to why the case is not complete or what steps are being taken to complete the case. Bureau Chiefs take these reports and manually add information relating to the cases. The information

capturing the reason for delay, actions to complete the investigation, and the expected date of completion are not entered into OIG's database.

OIG Response: OIG is currently developing an electronic case management system to improve upon our timeliness and enhance the management of our cases. However, it cannot be stressed enough that exhibited information is not a true reflection of the actual number of days a completed case is in review for final approval. As noted by the Auditor General, the information in our existing database does not accurately account for cases initially submitted for review that are returned to the investigator for additional investigative work. Our review of the Auditor General's sample case reviews indicated that nearly all cases, once fully investigated, were reviewed within the time frames set forth within the OIG Directives Manual.

8. The Inspector General should continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules.

Findings: Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by OIG administrative rules. The current administrative rules require that allegations of abuse or neglect be reported to the OIG within four hours of discovery.

In January 2002, the OIG increased the required reporting time from one hour to four hours. There have been improvements in the timely reporting of incidents since the last audit in 2002. Community agencies continue to have untimely reports in comparison to facilities.

- **Facility** – 10% of facility incidents were not reported within the four-hour time frame in FY04 compared to 16% in FY02
- **Community Agency** – 42% of community agency incidents were not reported within the four-hour time frame in FY04 compared to 50% in FY02.

OIG Response: OIG is pleased that the audit documents improvements in the reporting of allegations of abuse and neglect within the four hour time frame. OIG will continue to work with providers to assure that reporting requirements are met. To assist in this process, OIG generates detailed reports of late reporters and tracks trends. In one case, OIG sent a letter threatening sanctions. Additionally, OIG seeks explanations for late reporting when the report is initially made, allowing ample time for follow up. OIG sends advisories to the provider and DHS division director responsible for monitoring that provider's performance. OIG case reports always recommend that agencies whose staff have reported allegations in a tardy fashion address that deficiency and require that the provider submit a corrective action plan to prevent further non-compliance. Finally, OIG

offers on-site training and other technical assistance to those agencies experiencing difficulty with meeting required time frames.

9. The Inspector General should send all community agencies copies of the Community Agency Protocol and training manuals and require the community agencies to adhere to the contents. This would help ensure that the community agency conducts the initial steps of an investigation properly for the OIG investigators.

Findings: OIG case reports generally were thorough, comprehensive, and addressed the allegation. All case files in our sample contained a Case Tracking Form and Case Routing/Approval Form.

Due to recent policy changes made by the OIG, community agencies no longer conduct a significant number of investigations for the OIG. In Fiscal Year 2004, 63 investigations were conducted by 40 community agencies.

- Community agencies now must accept the community agency protocol developed by the OIG and be properly trained or they will not be allowed to conduct any investigations for the OIG.

- As of January 1, 2002, OIG administrative rules were changed so that community agencies can investigate only abuse cases that allege mental injury.

Currently, the OIG requires that all community agencies that have accepted the protocol send investigators to be trained by OIG personnel. Attending this training by community agency staff is important because, once the OIG is notified of an allegation of abuse or neglect, the OIG has 24 hours to make a determination as to who will investigate. Investigations conducted by OIG investigators at community agencies are not likely to commence for several days since OIG investigators are not stationed at the community agencies. Therefore, the community agency must begin the necessary investigative steps to ensure that all evidence is preserved. In addition, without proper training the community agencies may not correctly assess an incident of abuse or neglect and may fail to report it to the OIG as required by law.

As of the end of March 2004, there were 399 community agencies that provided services to the developmentally disabled and mentally ill in Illinois. Of the 399, only 192 (48%) accepted the OIG protocol. In addition, of the 399 community agencies, only 156 sent staff to Basic Investigative Skills training and only 171 sent staff to Administrative Rule 50 training.

The auditors reviewed the six cases that were investigated by community agencies from our sample of 125 closed cases from Fiscal Year 2004. We noted exceptions in 3 of the 6 investigations.

OIG Response: OIG investigates all community agency cases where an agency has indicated that they do not want the authority to conduct their own. Of the tens of

thousands of agency employees, only staff trained in Basic Investigative Skills took investigative action in the sixty three cases handled by agencies. Moreover, any initial action requested of persons not trained in Basic Investigative Skills rarely includes more than providing copies of relevant documents. Untrained staff were not asked to conduct interviews, collect sensitive evidence, take needed photographs or take any other investigative related steps. OIG takes issue with any inference that untrained agency personnel conduct investigations and maintains that, in accordance with OIG directives, they are not engaging in investigative practices, nor does the report demonstrate that they have. Additionally, OIG does provide technical support to agency investigators, along with any necessary re-training needed to address noted deficiencies within their cases. It should be noted that all agency investigations are subject to the same supervisory review approval process that applies to OIG investigations. Given the small number of cases, which are referred to the agencies, requiring adherence to the Protocol by agencies who do not wish to conduct investigations will unduly interfere with OIG investigations (see exhibit III).A

AUDITOR COMMENT: *Over 190,000 individuals with mental illness or developmental disabilities were served by approximately 400 community agencies in fiscal year 2004. The audit is not questioning the training that the OIG provides to community agencies that chose to send staff to such training. Rather, the audit is noting that community agency staff who have not been trained may fail to correctly assess whether an incident of abuse or neglect has occurred which needs to be reported to the OIG. Also, since several days may pass before an OIG investigator arrives on-site at the community agency, it would seem reasonable for the OIG to take steps to help ensure that community agency staff are knowledgeable so that an investigation is not compromised by improper evidence handling before an OIG investigator arrives.*

Based on analysis of OIG investigations at community agencies from our sample cases, it took the OIG an average of 42 days to conduct interviews with victims. In 22 of the 36 investigations, the first OIG interview with the victim was conducted after a week had passed.

10. The Inspector General should ensure that statutory requirements are met by developing and implementing a comprehensive and ongoing training program.

Findings: The OIG did not comply with the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.5) to provide continuing education to its investigators. The Act requires the OIG to establish a comprehensive program to ensure that every person employed or newly hired to conduct investigations shall receive training on an on-going basis. The directive on training stated that OIG investigators were required to have 10 hours of continuing education annually.

In Fiscal Year 2003, 10 OIG investigators and two supervisory staff had less than 10 hours of training. Seven of the 12 only received a half of an hour of training on the Health Insurance Portability Accountability Act (HIPAA). This training was State-mandated and consisted of standards for the exchange of health information and the requirements for

confidentiality and privacy concerning a person's personal health records and information.

In FY04, 14 OIG investigators and three supervisory staff had less than 10 hours of training. The majority of this training was on two State-mandated courses: HIPAA Phase II and the State of Illinois Ethics Training Program. In addition, 10 of the 17 also had less than 10 hours of training during FY03.

Although 10 hours of continuing education is no longer required by the OIG, Illinois statute requires a comprehensive training program where every person employed or newly hired to conduct investigations receives specific training on an ongoing basis.

The auditors reviewed the training hours and courses for the two investigators hired in FY03 and found that they both received all orientation and initial training courses. They also reviewed the training hours for the six investigators hired during FY04 and found that all six investigators had more than 50 hours of training in various areas by the end of the fiscal year.

OIG Response: OIG has already taken steps to comply with training requirements set forth in its directives. In September 2004, OIG held its annual statewide training for all OIG staff which included two and a half days of investigative training, review of trends and patterns of allegations and findings, timeliness of investigations, investigative case planning, interviewing MI and DD persons and review of organizational performance. OIG's training directive has been revised to include specific classes and training goals. In addition, staff are assigned several Net Learning computer-based training courses which are required within a specific time frame. Targeted bureau level training specific to the needs of each bureau has begun. Lastly, individualized training objectives are established for each employee during evaluation periods.

11. The Secretary of the Department of Human Services and the Inspector General should work with the Governor's Office to get members appointed and reappointed to the Board, and should assure that the Board meets quarterly as required by statute (210 ILCS 30/6.3).

Findings: The Abused and Neglected Long Term Care Facility Residents Reporting Act establishes a 7-member Quality Care Board (Board) within the Department of Human Services' Office of the Inspector General. One of the requirements of the Board is to meet quarterly. The Board met quarterly in all of Fiscal Year 2003 and all but the first quarter of Fiscal Year 2004. However, even though the Board met, it failed to have a quorum at 7 of the 8 meetings during Fiscal Years 2003 and 2004.

OIG Response: OIG has been working closely with the Governor's Office of Boards and Commissions regarding the appointment of board members. We will also continue to work closely with the President of the Board to encourage quarterly meetings.

12. The Inspector General should ensure that its Annual Report is submitted to the Governor and to the General Assembly no later than January 1st of each year as required by the Abused and Neglected Long Term Care Facility Residents Reporting Act.

Findings: The Office of the Inspector General did not submit its Fiscal Year 2003 Annual Report to the General Assembly and to the Governor in accordance with State law. The Act requires the OIG to submit the Annual Report to the General Assembly and to the Governor no later than January 1st of each year. The report was printed in February 2004 and delivered in March 2004.

OIG Response: The Inspector General will ensure that all future Annual Reports are submitted timely. The FY04 Annual Report has been completed and has been approved for printing.